Workers' Compensation Fraud Report

Fiscal Year 2002

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Department of
LABOR AND
INDUSTRIES

October 2002

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EXECUTIVE SUMMARY

During fiscal year 2002, the Department of Labor and Industries (L&I) spent $3.9 million to detect fraud in the state workers' compensation system. The amount assessed through administrative fraud orders, settlements, assessments, cost avoidance and court orders was $10.7 million.

This is the eighth fraud report mandated by RCW 43.22.331, which provides, "The department shall annually compile a comprehensive report on workers' compensation fraud in Washington. The report shall include the department's activities related to the prevention, detection, and prosecution of worker, employer, and provider fraud and the cost of such activities, as well as the actual and estimated cost savings of such activities. The report shall be submitted to the appropriate committees of the legislature prior to the start of the legislative session in January."

While the cost of discovered fraudulent activity is easily identified, total cost-avoidance benefits to the system are not. The deterrent effect of media coverage and exposure on contemplated fraud or abuse cannot be measured.

Several areas in the department work to expose fraud and abuse. The Investigations Unit identifies workers and pensioners who fraudulently obtain benefits. Field audit activity identifies employers who underpay or evade premiums for their workers, and the Provider Investigations Unit identifies providers who have billed for illegitimate or exaggerated services.

In response to Executive Order 97-03 Quality Improvement, which directed each state agency to develop a quality improvement program, the department continues quality improvement studies related to fraud. Process improvements approved by executive management are being implemented. These changes are mentioned in this report.

BACKGROUND

While media coverage of L&I's fraud effort has mainly focused on worker and provider fraud, those reports tell only part of the story. The department has successfully detected fraud and abuse in other areas within the $1 billion annual workers' compensation system, including employers who falsely report hours and providers who improperly bill the department.

Compliance audits and educational field activities are designed to assist employers and providers in avoiding reporting and billing errors. These inadvertent mistakes can result in penalties and delays in account payment. Most audit efforts, administrative orders for recovery and civil court actions do not attract media attention; however, they are an important part of prevention.

Several other methods are used to reduce fraud, including, a pension cross-referencing system, coordination with other government agencies, and an on-line fraud reporting system via the Internet. Improved computer-based discovery and database reporting systems implemented in 1999 improved the department's ability to address fraud. The department also cooperates with workers, employers and the provider community to research and enact more effective legislation. An example was the extension of the statute of limitations from one to three years to demand re-payments induced by fraud. That legislation passed during the 1998 legislative session.

Three areas of fraud are discussed in this report: employer, worker and provider.

Employer fraud involves employers who knowingly misclassify employees in lower-cost rate classes, under-report worker hours, or fail to pay required premiums.

Worker fraud occurs when an employee receives benefits by fraudulent means. Worker fraud usually receives more public attention because it is detected and reported more often. The Investigations Unit focuses on this area.

Provider fraud involves billing for fictional services or overuse of medical services. This type of fraud is the most difficult for the department to detect. The Provider Fraud Investigations Unit was established to address this area of fraud and abuse.

Employer Fraud

Field Audit

This program's primary duties include:

- verifying employers' premium reporting
- educating employers on reporting requirements for premium payments
- conducting classification surveys to ensure that employers report in the proper industrial insurance classification.

Premiums are determined by comparative risk analysis. Businesses in higher risk classifications,

such as logging or construction, pay higher premiums. Some employers try to lower premiums by reporting worker hours in lower-risk occupations. Some residential construction employers do not pay premiums at all. These underground economy employers have an unfair competitive advantage over those who do pay premiums.

The Field Audit section's 43 auditors routinely coordinate with other state agencies to investigate cases of potential fraud. During Fiscal Year 2002 (FY02), the Field Audit Program conducted 3,150 compliance audits and 40 educational workshops for employers that resulted in the assessment of $ 8 million in additional premiums. The interaction between the auditors and the public brought to light many instances of potential fraud.

Operating Costs	Assessments
$3.4 million	$8 million

During FY02, the L&I Field Audit Program concentrated on identifying, locating and auditing wood framer employers. As a result of this emphasis, the program audited over 1,000 employers. Of those audited 575 framing employers were found to be out of compliance and were subsequently brought into compliance. This resulted in the assessment of $2,300,000 (part of the $8 million mentioned above).

*Operating costs are the total expenditures related to the program, which includes, compliance and educational audits.

Residential Wood Framing Initiative

The department launched a program to bring all framers into compliance and increase the number of hours reported in the residential wood frame construction industry.

In 2002, the department more than doubled the number of previously unregistered framers who opened worker compensation accounts as a result of an audit. These cases came from public referrals to our hotline, and referrals from other programs outside of audit who worked with the construction industry. Department auditors conducted 1,032 audits to ensure framing employers met reporting requirements. This was almost four times the amount of audits historically performed within this industry. Letters were sent to employers who did not report hours but maintained an open account. Finally, the department provided assistance and education to new framing employers opening up accounts on reporting requirements.

The results were twofold. We brought 230 unregistered framing employers into the worker compensation system. The previous year, only 108 were identified. Our audits assessed 809,132 additional hours, or more than two-and-one-half times the usual rate.

In the next Fiscal Year, the department expects to increase the number of employers who report hours in this industry through continuing to find unregistered employers, maintaining a focus of audit resources in the industry, increasing education and outreach efforts, and working with general contractors to ensure sub-contractor compliance.

Future Activities

In Fiscal Year 2003, the department will start a project designed to not only continue identifying all employers who fail to open industrial insurance accounts, but also collect dollars for past due premiums. Since we began focusing on "unregistered" employers in July 2000, we have found over 1,350 unregistered employers and brought them into compliance. We now want to step up our efforts to collect the money they owe the department, both through the payment of premiums since opening an account, as well as dollars owed from previously unreported hours.

We also have a goal to get more Framers reporting hours. Currently more than half of all accounts with the framing risk class report zero hours worked in framing. We believe there is underreporting going on, so Audit and others will attempt to get more employers reporting the actual hours worked.

Worker Fraud

The department's investigative staff investigate worker and pension fraud cases. Allegations of inappropriate activity and cross-matches with other governmental agencies drive the majority of fraud investigation assignments. The department's fraud adjudicators issue administrative fraud orders as a result of investigations. Criminal charges are sought in the most egregious cases and are pursued through individual county prosecutors.

Validity, activity and fraud investigations (defined and described below) all contribute to prevention. The specific benefits from media exposure of such activities are impossible to measure. However, the sentinel effect deters others from contemplating fraudulent activity. It also encourages others to report cases where abuse is suspected. Historically, anonymous tips have provided the greatest percentage of investigative leads. During the past three years, however, a cross-match with Employment Security Department data has been the most productive. This is the breakdown of discovery sources resulting in a fraud order during FY02:

Discovery Source	FY01	FY02
Anonymous	11%	16%
Claims Managers	10%	9%
Employers	14%	5%
Employment Security	53%	58%
Other Internal	3%	5%
Internet	4%	1%
Vocational Counselors	4%	3%
Attending Physicians	1%	3%
	100%	100%

Validity investigations are conducted to assist the claims adjudicator in deciding if a claim is allowable. If a claim is allowed, employers may protest the validity of a claim. A common basis for protest is that the injury did not occur during the course of employment. When an

investigation supports an employer's protest, the claim is rejected and the cost of the claim ends. In FY02, the program conducted 337 validity investigations.

Activity checks determine whether a claimant's actual activities conform to the reported physical limitations that justify the claim. Allegations of inappropriate physical activity are investigated to ensure claimants are not engaged in unreported employment or in activities beyond their alleged physical incapacity. These investigations can result in early claim closure and termination of benefits when claimants are found employable resulting in a significant savings to the State Fund. There were 1,596 activity checks conducted in FY02.

The department begins a fraud investigation when an activity check reveals that a claimant has received benefits by fraudulent means. Once fraud is discovered, an administrative fraud order is generated, demanding repayment of time-loss, pension, medical or vocational benefits. This repayment order includes the amounts received and a penalty of up to 50 percent of the claim cost. A total of 134 administrative fraud orders totaling $2.5 million were issued in FY02. During the same period 49 overpayments were issued totaling $343,833 with a one-year cost avoidance of $283,344.

Action	**Number**	**Dollars**
Administrative Fraud Orders	134	$2.5 million
Overpayments	49	$343,833 + $283,344
Total	183	$3.127 million

Discovery methods and inter-agency cooperation is expanding. L&I entered into a data sharing agreement with the Department of Social and Health Services (DSHS), which allows L&I to cross-match newly hired employees against workers receiving time-loss benefits.

Cross-referencing with the Employment Security Department continues to identify fraudulent activity. The resulting data compares claimant benefit recipients' social security numbers with employers reporting paid wages during the same quarter. Employers are then asked to provide payroll records to establish if a claimant received benefits while earning wages.

The department continues to cross-reference with the U.S. Social Security Administration to detect those receiving workers' compensation pensions in the name of deceased persons.

Some cases result in criminal prosecution when deemed appropriate by the county prosecuting attorney with jurisdiction over the case. These cases are submitted to county prosecuting attorneys when the department's investigators, adjudicators and assistant attorneys general agree on that course.

Once a fraud adjudicator issues a binding administrative fraud order, it is forwarded to the department's Collections Section for recovery. Collections staff attempt to recover overpayments by filing liens and conducting searches for assets such as payroll, and bank accounts. A review for current employment is completed every three months on individuals owing the department under this scenario. Restitution from criminal convictions is also processed through this section. In FY02, the department recovered $703,093 from this activity.

Program Costs and Assessments

Program	Operating Costs	Assessments	Overpayments	Fraud Collections
Investigations	$174,000 *	$2,523,238	$343,833	
Collections	$ 17,890 **			$703,093

*The operating costs shown for Investigations reflects only those costs associated with the investigation of the 134 cases resulting in the issuance of an administrative fraud order.

The costs do not reflect the costs to conduct Validity and Activity investigations that did not lead to the issuance of a fraud order. Also they do not capture the costs to conduct Industrial Insurance Discrimination investigations, provide training mandated by Excecutive Order 98-02, and the administrative costs to support the program. The total annual budget for the Investigations Program is $2.7 million

** The operating costs for Collections are only those dollars associated with the collection efforts stemming from fraud investigations.

Update on last year's plans

We are continuing to pursue reciprocal agreements with other agencies, and advertising successful civil and criminal cases via the news media. While the direct benefit of this practice is difficult to measure, the sentinel effect is worthwhile if it deters any would-be offender. Fraud adjudicators prepare and release information through the department's Public Affairs section on cases that are successfully resolved.

Additional claims staff have been hired and trained to resolve most validity issues. Investigations staff have been trained to effectively address activity investigations that result in the discovery of fraud. Claims staff continue to resolve cases that would have required investigators' time. This allows investigators to spend more time on activity checks and fraud.

Executive Order 98-02 mandates certain training for state employees who perform investigative duties. During this reporting period, training was provided to 260 L&I staff in nine, two-day sessions, and six, one-day sessions. We will continue to provide this training on a quarterly basis. This continuing educational process ensures that staff members are apprised of relevant case law, significant decisions of the Board of Industrial Insurance Appeals and investigative issues as they arise.

We are continuing to focus on investigation process improvements. The department’s emphasis on the timeliness of activity investigations continues to favorably impact the management of workers’ compensation claims by getting information to claims staff sooner, thus allowing them to make more timely adjudicative decisions. More timely investigations also will shorten the duration of fraudulent payments.

Future Activities

L&I continues to modify the focus of our investigative staff and discovery methods to concentrate on investigations that impact the State Fund. The department will continue to expand discovery methods through cross matching with other agencies and states. While developing reciprocal agreements with other states is time-consuming, they continue to show great promise. The new-hire cross-match with DSHS has been an effective tool in combating fraud.

Provider Fraud

Vocational and Health Care Provider Review and Education Unit

Auditors in the Vocational and Health Care Provider Review and Education Unit conduct audits of vocational and health care providers to ensure compliance with department laws, rules, policies and the medical aid fee schedules. Occupational Nurse Consultants (ONC's) also coordinate with the Department of Health's professional disciplinary boards on issues of integrity and quality of care, and take appropriate actions against a provider's ability to treat injured workers based on department findings or disciplinary board actions. The unit also conducts provider-billing workshops and coordinates provider education seminars with the Office of the Medical Director.

Due to staff vacancies during the period covered in this report, medical auditors did not conduct billing workshops and educational meetings with specific medical providers. Two audit staff were hired in early summer and are developing a training program. Provider billing workshops began in the first quarter FY03.

Medical auditors primarily rely on referrals from department staff and citizens to uncover leads. When reports of questionable provider billing practices are received, staff investigates and conducts an audit or prepayment review in those cases where abuse of the system likely exists. Medical Auditors assessed and received recoupment of $183,185 from two providers, and revoked the provider number of another provider. The Unit had one Medical Auditor for three months of the reporting period and no auditors the remainder of the time.

Vocational auditors issued 21 orders as the result of audits and investigations. These orders resulted in assessments of $86,759.

Occupational Nurse Consultants referred 13 providers to Department of Health for potential licensure action, negotiated a settlement with one provider that included an agreement not to treat injured workers, and conducted ongoing monitoring of the quality of care given by 3 providers. Three orders were issued to remove providers from the Independent Medical Examiners' Approved Examiner List based on worker complaints.

Program costs and activity described below are for provider audit.

Program/Activity	Operating Costs	Assessments	Recoveries
Medical	$ 20,650	$183,185	$333,830*
Vocational	$245,262 **	$ 86,759	$ 81,416
Total	$265,912	$269,944	$415,246*

* Recoveries include both current year and prior year assessments.
** The operating costs are the costs of salaries for the auditors, to include the cost of the audit staff who were in training and not actively conducting audits.

The Unit has approximately $550,000 in receivables due the department as a result of prior year audits. Although the Unit uses collection agencies and other means to recover funds owed the department, the lack of statutory authority to place a lien on a provider's property limits our ability to recover these funds.

Provider Fraud Investigations Program

During this reporting period, the Provider Fraud Program was in its fourth year. The unit is currently comprised of one investigator and one auditor, with assistant attorneys general and county prosecuting attorneys providing legal representation. During this period, staff investigated or conducted audits of 65 referrals resulting in $2,396,152 being assessed, with a one year cost avoidance of $515,304.78.

The primary source of fraud detection was through the U.S. Attorney's Medical Fraud (MedFraud) Task Force, private insurers and the analysis of provider billing practices. The Provider Fraud unit continues to work closely with the MedFraud task force, FBI, Postal Service, private insurers, National Insurance Crime Bureau, law enforcement agencies, and prosecutors from various counties.

Referrals for FY02:	65
Investigations Closed:	40
Operating Costs:	$ 223,000
Assessments:	$2,396,152
Recoveries:	$ 230,845

The Provider Fraud Unit's focus this fiscal year was the investigation of a chiropractic firm, several translators, a chiropractor who assumed the identity of another chiropractor in order to provide care to injured workers, and a physical therapist who billed for services not performed. The two doctors associated with the chiropractor firm were sentenced in federal court and are currently incarcerated in a federal prison. The cases involving the translators are still on going but it appears that the amount of fraud will be significant. Though not in the reporting period covered by this report, the case involving the chiropractor who assumed another's identity was settled in November 2002 with the chiropractor being incarcerated and ordered to make

restitution to the department in the amount of $12,670. The case involving the physical therapist has been filed with the King County Prosecutor's Office and is awaiting trial.

Additionally, two other providers with abusive billing practices were referred to the department's Provider Review and Education unit for administrative action, such as recovery or education, as appropriate

Conclusion

The department is dedicated to reducing fraud and abuse. Increased effectiveness has resulted from improvements made thus far. The investigation of worker fraud will continue to explore discovery methods to disclose additional fraudulent activity. Continued pursuit of employer and provider fraud issues will reap additional benefits. The department's efforts related to fraud and abuse will continue to be refined and improved, as resources and technology are made available.